

24-32-85

CANCER IN CHILDHOOD: A CATASTROPHE IN THE  
FAMILY AND IN THE COMMUNITY

In spite of improvement in the management of cancer by the therapeutic modalities of surgery, radiation and chemotherapy, the diagnosis of cancer still strikes terror to the heart of the listener. Patients who face the inevitability of death realistically frequently confess that when they die they would like it to be from any cause other than cancer. Because the diagnosis of cancer is usually made in the latter years of normal life expectancy and because cancer and death are so frequently associated in the mind, when the diagnosis of cancer is made in a child, the impact upon the family is devastating and the community views it as a catastrophe.

The death of your grandmother or your mother or even your spouse from cancer although perhaps not expected is at least believable. The diagnosis of cancer in a child is not only difficult to believe; it is unthinkable. It is my intent to examine with you some of the effects of the diagnosis of cancer on a family and on the community. When I refer to the community I refer to the community of health care professionals who care for the child as well as the broader community where the child lives. Any discussion of the diagnosis of cancer and its impact on other people is more or less automatically linked to the management of the seriously ill and dying child and his family. This is true because in spite of the major therapeutic advances that have been

made in the management of solid tumors and leukemia to the end that the mortality is considerably improved, more children still die of cancer than are cured of it.

#### SKILLS IN PROFESSIONAL MANAGEMENT

No one enters the medical profession skillful in managing the problems that are generated in the hospital, in the family, and in the community by the seriously ill or dying child. When the diagnosis is cancer, the physician's role is more difficult and the skills he requires are harder to learn. The physician who understands his role in the treatment of disease and the postponement of death for as long a time as possible, frequently does not understand his role in making the serious illness of a child, his impending death or his actual death as bearable as possible for all of those concerned. More than that, it may be that the physician himself is affected by the catastrophic diagnosis of cancer in a child and finds it difficult if not impossible to cope with the multitudinous problems that surround this diagnosis.

#### SCOPE OF THE PROBLEM

The problems in management are related to the patient himself, the patient's parents, the broader aspect of the patient's family, particularly his siblings, the hospital personnel, and the community. Each of these requires a different approach, a different understanding, and a different management goal but if that were not difficult enough, it must also be recognized that these management goals vary

at different times in the course of the child's disease. There is a special set of circumstances requiring specific management at the time of diagnosis. If the child's therapy is not ultimately successful and death is inevitable, a different set of management goals present themselves as the child approaches death. Then the physician who frequently ceases to play a role in the management of his patient's family when his patient dies, finds that there is a special relationship to the family of a child who died of cancer immediately after death. And finally in cancer, as nowhere else with the possible exception of an occasional circumstance surrounding a congenital defect, there are long-term effects upon the family which can be softened by the physician provided that he understands <sup>that</sup> his role / <sup>must</sup> continue in time long after the death of his patient.

#### REWARDS TO THE PHYSICIAN

The rise of <sup>the specialty</sup> oncology in pediatrics makes the team approach to the management of the child with cancer a necessity. Although there are many advantages to having so many individuals and specialties involved in the care of the cancer patient, the risk is the impersonal facade of the team. There must be one individual designated to carry the responsibility of the primary physician.

While it is true that no one enjoys the management of the emotional problems surrounding the dying child, there is nevertheless a satisfaction to the one who serves as guide

through difficult times to the end that the family is salvaged, the community is able to get on without bitterness toward the hospital or the medical profession, and the hospital staff is able to return to the routines of care knowing that they have <sup>played</sup> / a positive role in an unpleasant situation. For this reason, the physician assigned the primary role must be chosen carefully. The process of relating to the family and to the pediatric patient must begin at the very first encounter between physician and family. I believe that with solid tumors the surgeon who will be responsible for the operative procedure is the best person to be assigned the role of primary physician. He must project his integrity, his capacity for compassion and understanding, in such a way that the family will be assured during the time of diagnostic confirmatory studies that when the diagnosis is eventually known, the surgeon will not only be honest in his dealings with the family, but will to the best of his ability help them to understand the situation and bear the burden. This does not mean of course that the surgeon must share all of his concerns with the family before the diagnostic studies have revealed an exact diagnosis. Even though there may be relief on the part of the family if the prognosis is less than grave, it is cruel to put a family through the possibility of facing a hopeless prognosis before the surgical procedure that proves it ~~is~~ carried out. Usually, the family is keyed to a high pitch at the time the unpleasant news must be broken because it is common that a biopsy, a surgical procedure, or a major diagnostic study confirms the diagnosis, establishes the prognosis within reasonable limits, and sets the stage for adjunctive therapy over the course of months or years.

## CONTACT WITH THE FAMILY

When the moment comes for the surgeon to meet with the family, attention to a number of seemingly unimportant details will have much to do with the family's emotional stability then and in days to come. First of all, a conference between the surgeon and the family must be in the best of all possible environments, such as a room designed for that purpose, the surgeon's office, a quiet lounge, etc. The revelation of the diagnosis of cancer should not be told to the parents on the ward, in the corridor, in the out-patient clinic or in the lobby of the hospital, or anyplace where a family cannot let their emotions be demonstrated in any way they see fit without embarrassment. Secondly, if it is at all possible, both parents should be together at this time. If anyone other than the parents is to be present, the surgeon should be certain that it is a stable member of the family who will support rather than hinder the management. Under no circumstances should this be an announcement to a large segment of the family such as frequently gathers around the parents in a time of crisis. Sometimes the pastor of the family is a helpful member of the conference.

The surgeon's actual words to the family must be well chosen. They must not only fit his personality but they should be gentle rather than abrupt, compassionate while being factual, and free of scientific terms that are not understood by the family. When a family has been waiting for several tension-filled hours to hear the outcome of a laparotomy, the announcement that the diagnosis is that of a malignant tumor with a grave prognosis may not be compre-

hended at all.

I have found it valuable to begin such an encounter with the announcement that the child is in recovery room, that the operation is over, and that he is in satisfactory condition. If the physician will then continue by saying that the diagnosis suspected has been confirmed, the family is eventually able to understand that the surgeon was not taken by surprise with the diagnosis. A pause on the part of the surgeon at this time may trigger an emotional outburst and for that reason I usually continue to keep talking about relatively unimportant things while the family absorbs the first shock of the revelation of the diagnosis of cancer. I then begin in very general terms to outline the steps that we will be taking immediately and in the long-term to insure the best possible outcome for their child.

It has been my custom for years to say as little as possible on this first occasion after the diagnosis because I have learned that little else is comprehended by the family except the diagnosis and its grave prognosis. Therefore, I tell the family that I will see them again shortly and talk about the future. No matter how hopeless the situation may seem to me, I never share utter hopelessness with the family.

There are families in this situation who hear only what they want to hear and this can be learned by posing a question or two to the family when next they meet with the physician.

If this is the case, then facts must be spelled out exceedingly carefully and perhaps should be done in the presence of another member of the family who will be able to reiterate the physician's point of view from time to time.

After announcing the diagnosis to the family, the physician can usually tell whether this is a time when the family would like to be alone or <sup>whether</sup> they would prefer to have the continuing support of a stranger who is obviously trying to be a friend. This is the time when the surgeon must be all things to all men. A kindly gesture such as a arm around the father or holding the hands of both parents as they sit facing you may seem at times like an embarrassing gesture to the surgeon but it is frequently remembered in days to come as an outstanding act of support. Some families have a flood of questions at this time and if so, they should be answered. But whether then or later, there are certain things that have to be told to the family in reference to what they might expect to encounter outside the hospital.

#### THE FAMILY AND THE COMMUNITY

One of the things that the physician must prepare the family for is the reaction of the community whether that community is composed of a few friends of the family, the immediate neighbors in the city, or the larger community of a small village or town. ~~I know that Frenchmen are more private people than are Americans, but I suspect that human nature is not significantly different in our two countries.~~ The diagnosis of cancer in a child is accepted as an affront by the community and in an effort to be helpful, actions may

be precipitated that will not in the long run be of benefit either to the child or his parents. Almost inevitably some friend or neighbor is convinced that a different physician, a different medical team, or different hospital would be superior to the present arrangement. Not because I fear another opinion, but because I am concerned about the family's emotional stability, I tell them that they will be given many suggestions by well-meaning friends. I also suggest that some of these well-meant intentions can direct a patient to a charlatan rather than to a second competent opinion. The family must be assured that bona fide therapy is never the property of one man or one clinic but is available to all reputable physicians. I have found it helpful to suggest to the family that if there is anyone that I know that has something to offer that our institution cannot, I will see to it that the child has the benefit of this additional consultation. I further say that if there were anything unique that could be offered the child in another center, I will see that the referral is made and the economic burden eased if such is a problem. My suggestion to the family is that the way to avoid confusion is to inform me of any advice that sounds reasonable and logical to them. If I know what it is about, I will discuss it with them; if I do not, I will investigate and report back promptly.

#### THEOLOGICAL CONSIDERATIONS

I have taken as much trouble to spell these things out because in dealing with cancer patients for more than thirty - *five*



years now I have lost only two children to cancer charlatans and one of these returned to me. I look back on those occasions and believe if I had been more specific with the families earlier, both of these tragic circumstances could have been avoided. It used to be said during World War II that there were no atheists in fox holes. I have also found that there seemed to be very few atheists among ~~the~~ parents with dying children. This is a time when religious faith can be of tremendous support to a family going through difficult circumstances.

Miraculous cures have been sought by religious people for years. In days gone by this was usually in the Roman Catholic confession, but recently charismatic movements in Protestantism have attracted people to faith healers. The support that a family obtains through their religious faith might be immeasurable in some instances and never should be downgraded, but on the other hand some so-called faith healing is made contingent upon the amount of faith engendered by the family. This means that if a miraculous cure does not take place, the family is convinced that their faith is shabby and they have the problem of guilt added to the emotional problem of the seriously ill child.

If the question of a miraculous cure is introduced by the family, I usually tell them that I do believe in miracles but have never seen what I would call a miracle in reference to their child's problem. Naturally, any advice against seeking a miraculous cure comes better from someone with strong religious convictions than from one who is obviously on the other side of the fence.

For this reason it is well to work closely with the families' clergymen if this is their wish.

In line with what I said previously about having to be all things to all men at a time like this, I can only speak from the standpoint of my own faith when I am asked such questions as, "Why did God do this to my child?", or "What have we done to be punished like this?", or when I hear statements such as, "All we can do is hope and pray." I attempt to meet the family on some compatible ground that will not be argumentative/<sup>and</sup> that might be reassuring. I have found that families are comforted by being told that the God they question is sovereign and does not act capriciously. I am convinced that it has helped many of my cancer patients' families to hear me say that if I did not myself believe in the sovereignty of God I would find it most difficult, if not impossible, to be caring for their child. If the family requests me to talk to their minister,/<sup>I do so.</sup> If they want me to talk to their relatives now that the first awful crisis is past, that is also reasonable. If they ask me to pray with them, I pray with them. About the only thing you cannot do, as much as you might want to, is to cry with them. Hospital chaplains can be invaluable at times yet I believe that parents appreciate <sup>SPiritual</sup> ~~non-medical~~ support from their physicians.

There probably has never been a relationship between parent and child in which, under stress, the parent could not find a cause for guilt. These feelings of guilt become

exaggerated at the time of the grave illness of a child. So frequently do parents, particularly mothers, consider the affliction of their child to be punishment from God that it is commonly openly expressed. No matter what one's theological doctrine on punishment might be, parents benefit by the statement that such an affliction of a child in punishment of a parent would be evil and that no evil comes from the hand of God.

### THE FAMILY'S QUESTIONS

It is inevitable in a medical center, particularly one staffed with physicians, residents, Fellows, and students that all statements made about a child's illness will not conform to the statements made by the primary physician. It is well to point out to the family that if any questions arise because of variations in opinion and advice, that the surgeon is always available and will try to answer the questions and put things right. Obviously it is important to train a house staff that we must be of one mind and one goal in these situations. High in priority for the house staff is the admonition that never must a promise be made that cannot be fulfilled.

After the diagnosis of cancer is made in a child and a course of therapeutic action is underway, there is a lull in the relationship between the physician and the family. This is the very time that the physician must be aware that the family of his patient is now particularly vulnerable. The diagnosis of cancer in a child destroys

the autonomy of the family. This whole catastrophe is outside their knowledge and they now have to be dependent upon technology they do not understand and physicians they have only just met.

Secondly the family is partially immobilized,--paralyzed, if you will--by the very diagnosis of cancer in their child. The family will be asked to make decisions now in conjunction with their physicians about the future of their child, decisions of which they know little and their dependency becomes great. Underlying it all is the awful sense of unreality that they have a child with an old person's disease.

This is the time when parents inevitably ask such questions as, "How long?"/"Will he be well again before he dies?"/"Can he go back to school?"/"Will he suffer?"/"What will I tell his brother and sister?"

These questions must be faced head-on by the physician and answered out of his experience to the advantage of the particular family in question. Frequently one must truthfully say that the youngster will be so well for a time that the parents will doubt the diagnosis and the prognosis. The question of returning to school, for example, must be individualized, but in general, if a child feels well, it is probably best for him to go to school. Even if his life expectancy is limited, it is very difficult for a family to have what amounts to a death watch around a seemingly well child. When he begins to show signs of the ravages of his disease and school becomes difficult for

him either physically or mentally or emotionally, he probably should stay at home. In some instances school for half a day is good for morale all around. The promise to alleviate suffering can always be made but it should also then be kept. There are a number of pain-killers and sedatives which when used with tranquilizers can keep the patient ~~almost~~ pain-free.

The most difficult question to answer, of course, is the one concerning the time of death. Although it cannot be definitely answered, there are some pitfalls to avoid. The first thing to do is not be specific because the course of disease is too variable. Children have very little concept of time as compared to their parents. Well-meaning friends often suggest a Christmas party in October for the child who may die in November. I believe this should be avoided at all cost because it takes its toll on the family, the community, and frequently on the child himself out of all proportion to the associated reward.

#### THE PATIENT HIMSELF

We sometimes become so involved with caring for the distraught family of the cancer patient that the patient himself is neglected in reference to the emotional support that he needs. There is no doubt that honesty is essential in dealing with children because they can detect a fraud

immediately. Few children really inquire if they are about to die; some do ask if they are ever going to get better. To the latter type of questioning, I frequently say something like, "Of course you are going to get better but ~~it is also true that~~ I think you will feel worse before you start to feel better."

I am convinced that many more children have known they were dying than shared that information with me. Some knew it and kept it from their family. With a few I have discussed death at their request. I have not seen a child upset by this. With many children I have talked about the close call that they had with death,--but only after the fact. One can usually feel his way along this path and be guided by the child. Adult patients who may not fear death itself, almost always have tremendous anxiety about the dying process. It has not been my experience that this is the same concern with children.

I well remember one little girl dying of far advanced metastatic neuroblastoma who was so unlike a dying child that she frequently presented a disciplinary problem to her parents. When she would be threatened with physical punishment, she would reply with such quips as, "You wouldn't hit a child with cancer?" or "Is that any way to treat a dying child?" As difficult as the approaching death of this child was, there was no overwhelming gloom in the family even as the child talked about her early reunion in heaven with her

grandmother.

## [ THE INTENSITY OF TREATMENT ]

In cancer management today there are a number of modalities of therapy such as radiation in its various forms and a variety of chemotherapeutic agents which can prolong life but where cure is not expected. In the process of prolonging life, undesirable situations are sometimes produced including prolonged pain or discomfort, complications from the tumor such as blindness or deafness, and all the side effects of radiation and chemotherapy. When palliation is the only expected reward from therapy, its use must be weighed against the benefit to be expected.

If the proper relationship is developed from the beginning between physician and family, a great deal can be accomplished in guiding the family's thinking along these lines before the occasion for decision actually arises. I believe that there are many circumstances when the terminal patient should be permitted to die as quietly and as gently as possible rather than to be the recipient of every conceivable combination of chemotherapeutic agent for the prolongation of life without the alleviation of his disease. A good example of this is the terminal patient with neuroblastoma

who might slip out quietly this week without extraordinary therapy but with <sup>such treatment</sup> / might last an additional month at the expense of a problem with pain, grotesque appearance, blindness or deafness. I have almost never had a family urge me to continue therapy under these circumstances if they were properly introduced to the subject earlier in the course of the child's illness.

Regardless of where one stands philosophically about doing everything possible or withholding extraordinary care, the physician must be on guard so that he never puts a family who eventually loses a child in the position of being able to say: "We didn't do all we could for our child," ~~or worse than that, "We didn't do this and so for him when you could have."~~

### [ HOME OR HOSPITAL? ]

As the terminal phase of the cancer patient's illness approaches, the physician might have the choice of choosing a hospital or the family's home for the time of death. There are no absolute rules about this, but in general I favor death at home for a child if it can be managed without undue strain on the family. Some parents feel they cannot cope with a dying child if there are other children in the family. On other occasions an elderly family member already ~~burdening the family with care~~ <sup>★</sup> might preclude the possibility of adding a dying child to the household. Although I am thoroughly convinced that the hospice for dying adults is a remarkable advance in our management of patients, I do not think a hospice for children has the same advantages.



The family should always know that there will be a place in the hospital for a quiet refuge as the end approaches and ★ that this facility will be for the family's convenience rather than for the patient's treatment. If the hospital facility is eventually used, it is desirable that the family be permitted free access to the youngster's room at all times, that it be a room not shared by others, that it be at a quiet end of a hospital corridor, and that the usual disturbing observations of vital signs be eliminated. The child's comfort physically and the family's emotional peace of mind should be the primary goals of the hospital team and if they are, the family's needs will be automatically taken care of. If the physician and the family choose to have the youngster's terminal days passed at home, I think ★ ~~must~~ be made a home visit/by the physician or by a competent member of the social service or nursing team to assess the feasibility of the plan.

#### PHYSICIAN AS EDUCATOR

Once the diagnosis of cancer is established in the child, I don't think that there is such a thing as too much information that can be given to the family. By telling the family all that they can absorb about the diagnosis and the advantages of therapy, not only is the physician's role changed from that of magician to one of reasoning therapist but it provides the necessary rationale needed by the parents as they see their child undergoing the discomfort and the

physical changes wrought by adjunctive cancer therapy.

Furthermore in the unique relationship of the family with a child with cancer to the community, this provides the educational means of dealing with that community. While it is not possible for the physician to find his way into the community, whether that be narrow or broad, and explain as best he can the problems of the diagnosis and its therapy, he can use the family as his representative to the community. I have never done this in a formal way, but I realize full well that what I have imparted to the family in the way of reasonable knowledge is in turn shared with the community which then is better able to lose its hostility toward the medical center which does not seem to be able to manage successfully this devastating problem of cancer in childhood.

The local hospital community deserves some attention too along these lines where a more formal presentation of the rationale of therapy can easily be presented. This is ever so much more necessary in the hospital environment where the child with cancer is a rarity than it is in a pediatric institution where cancer in childhood is more common and indeed may be <sup>cared for</sup> in one unit devoted to that purpose.

#### WHEN DEATH COMES

When death finally comes, there is a sense of release for the hospital staff, the community, and for the family. The family who loses a child with cancer really loses him

twice. They lose him first when they finally come to the realization that he has a hopeless diagnosis and a hopeless prognosis. They lose him the second time when physical death overtakes him. In a sense, the first death is more difficult and the second provides some feeling of relief. ↓

It should be said in passing that even <sup>in cancer</sup> the patient who recovers and eventually is called "cured" that the family goes through all of the same agonizing months wondering about the prognosis / that is experienced by the family that eventually loses their child. When the day finally comes when the physicians can talk about success rather than remission, there is a sense of unreality that is very difficult to bear. Surprisingly enough what would to the outsider seem to be an occasion for rejoicing and the opportunity to live life joyously becomes the time of an emotional breakdown. Families which have held together begin to precariously/disintegrate. Wives and husbands who clung to each other because they felt that support was necessary now wonder if they really need / each other. I believe that one of the greatest areas of neglect in the treatment of the child with cancer is the emotional management of the family who hangs on the precipice of the indefinite prognosis and is finally almost unable to comprehend that the days of waiting are over and that they have a living child.

→ When death comes if an autopsy is requested and permission is granted the parents are certainly entitled to know what the major findings were and it should become part of the physician's obligation to so inform them.

## BEREAVEMENT

There is probably no bereavement that can equal the loss of a grown child and many parents never really fully recover from the loss of their child. In my experience such parents are very much unlike ~~to~~ parents of children who die from any other cause. The child who dies because of an accident has

just as tragic a death albeit without the long drawn-out months of uncertainty before the inevitability of death is apparent. ~~Not~~ <sup>W</sup>hen ~~such~~ a child dies in an accident his death as a rule brings to a close the relationship between the parents and the ~~child's~~ physician. Such is not the case with the cancer patient. Most of the parents of my cancer patients keep in touch with me for some time, occasionally this relationship has stretched into decades. Knowing this, I make it a point to write a letter of sympathy to the parents of children who die from cancer ~~under my care~~ reiterating major points that I have tried to make in our previous relationship. These points are aimed at eliminating any guilt on the part of the family which I might have detected that they were harboring, include the assurance that everything humanly possible that could be done had been done, and indicates my availability at any time that the family might think a conference might be beneficial. The siblings of the child who dies of cancer <sup>should not be</sup> ~~are frequently~~ neglected in the bereavement which follows death. ~~Grieving and mourning are basic needs of all human beings in response to the tragic loss of an important person in their relationship. Children of three and sometimes even younger can understand death and they should never be fooled into thinking that their brother or sister will return.~~ Parents should not fear to share their bereavement with children. When the youngster knows why his mother and father, ~~as well as other relatives,~~ are unhappy, he himself finds support in their own behavior

and this enables him to express his own feelings of sadness. Open dialogue concerning the youngster who has died is probably the best way of dealing in honesty with the remaining siblings. Heaven becomes a very real place to parents who have lost a child and the conceptualization of this on the part of the remaining siblings is a source of comfort. ~~If at all possible~~ During the days immediately surrounding the death of the patient and the funeral, it is well not to abandon siblings to the care of others than the parents, ~~unless they are very close relatives and the siblings have no reason to feel that they have been abandoned in their grief.~~

There are normal patterns to bereavement which most physicians who deal with death come to recognize. This is a time when the bereaved individual may verbalize his feelings of guilt. He expresses his sorrow through crying and a recounting of anecdotes concerning the dead child. He keeps the memory of the deceased alive by reviewing and recounting their lives together rather than attempting to shut out the memory and he certainly establishes relationships with those who support him in his grief. The physician who sees these normal manifestations of grief can be a source of comfort and support along with family, friends and clergymen.

However, when abnormal signs of grief become evident as they frequently do with the death of a child, and they don't show signs of working themselves out in four weeks or so, there may be the need for pastoral counseling or psychiatric

help. Such symptoms of abnormal bereavement might be seen in the parent who seems now devoid of emotion and acts out his life rather than lives it. His social relationships are shattered and his affect is listless. He avoids former normal social activity and becomes isolated. In extreme circumstances he may acquire a psychosomatic condition as for example, asthma, or may even take on the symptoms that the child had just before death. Agitated depression and talk of suicide are also highly abnormal.

Although attendance on the bereaved parents may seem to be beyond the call of duty, the physician who dealt with the child who is now dead is in the ideal position to encourage the grieving parent to review step-by-step his life with the dead child. If he can only start the parent reflecting on the past with an appropriate remark, all he need be then is a willing listener. Grieving parents require the assurance that tears are normal and should never be told to be brave and keep a stiff upper lip. In this day  
to a grieving family  
when house calls/are so uncommon on the part of a physician,  
a brief telephone call is better than  
no contact at all.

#### CLOSING THE CIRCLE

The parents of cancer patients have the need more than the parents of children who die from other causes for what I call "closing the circle." Parents frequently feel the need to revisit the hospital where so many of the unpleasant things associated with the diagnosis, treatment, and death of their child took place. This is not a morbid reaction;

rather it is an attempt on the part of the family to  
<sup>THAT EXPERIENCE</sup>  
 terminate, in their own time in their own way, ~~that experience~~  
~~rather than to have had it terminated precipitously for~~  
~~them by the death of the child.~~ On that or/<sup>a</sup>subsequent time  
 the family may wish to meet their physician and this may be  
 the occasion when they ask the questions that have prevented  
 their relative peace of mind. These include such things as,  
 "If we had made the diagnosis earlier, might the outcome  
 have been different?" or "Would it have helped if so-and-so  
 had happened?" This is the time when I talk to parents about  
 "what-if" and "if-only". There is no circumstance in life which  
 ends unhappily where we do not have the opportunity to say  
 "what if" or "if only". We can be of great benefit to grieving  
 parents if, early on, we can coerce them into eliminating the  
 "what-if" and "if-only" questions from their minds.

Some parents have the need to keep in repetitive contact  
 with the physician who guided their child's therapy. The  
 burden on the physician under these circumstances is never  
 heavy and his availability should be total.

Many years ago the American physician, Dr. Edward Trudeau,  
 stated that the physician's role is "to cure sometimes, to  
 relieve often, to comfort always." There is no medical  
 situation where that role of physician pays bigger dividends  
 in the emotional stability of the family than in the care  
 of that family which surrounds the patient with cancer.

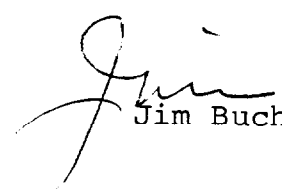


SUMMARY OF QUESTIONS PROPOSED BY AMERICAN ASSOCIATION OF  
COLLEGES OF OSTEOPATHIC MEDICINE FOR SURGEON GENERAL KOOP

- 1 - The costs of medical education are rising at a time when the Federal support is being withdrawn. Will this continue indefinitely? What implications does this trend have for physicians of the future?
- 2 - Delinquency rates on Federal student loans; Osteopaths have a low rate. Feds are cracking down. Is ratio likely to be turned around....or will students become more delinquent as their personal debts become larger due to changing fund sources?
- 3 - Prevention: what kind of major programs are needed in this area?
- 4 - Physician supply: Some studies show an oversupply of specialists, etc. What's down the road?
- 5 - Under-developed rural areas: What are Feds doing to assure more even distribution of health professionals?

Those expected to appear with Dr. Koop at the press conference:

Dr. Charles Moore, President of Association  
Dr. John Barson, President of the Oklahoma school  
Dr. William Miller, Chairman of Council of Deans



Jim Buchan

1. TIED TO ECONOMY. - ALTERNATIVE PATHS - BONDS FLOATED BY SCHOOLS, MEDICAL SOCIETIES
2. EVEN STUDENTS ARE ASKING FOR TOUCH ACTION MOOD IS TO PURSUE. THE MORAL FLAW IS THAT DOLLARS CAN PAY
3. SCHW-BRAIN - 5 INITIATIVES - SM-ROH - EXERCISE ACTION - AWARENESS
4. MARKET PLACE, ECONOMICS TAKING CARE OF SOME APPLICATIONS ↓, CLASSES WILL SHRINK
5. DOING WHAT WE CAN. UNDERMANAGED AREAS ARE SO DESIGNATED ON BASIS OF COMPLEX FORMULA - WE ASK FOR ADVICE - GRUPE'S SEEM TO COME FROM STATES THAT DON'T WANT